VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

September 12, 2018

Ms. Mary Jensen, Manager
Wintergreen Residential Care Home
3 Union Street
Brandon, VT 05733-1127

Dear Ms. Jensen:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 13, 2018.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PRINTED: 08/23/2018
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0593	A. BUILDING: _____ B. WING _____	08/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINTERGREEN RESIDENTIAL CARE HOME	3 UNION STREET BRANDON, VT 05733

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site re-licensure survey was completed by the Division of Licensing and Protection on 8/13/18. The following regulatory violations were found.	R100		
R135 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 Assessment 5.7.b If a resident requires nursing overview or nursing care, the resident shall be assessed by a licensed nurse within fourteen days of admission to the home or the commencement of nursing services, using an assessment instrument provided by the licensing agency. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that the admission assessment for 1 of 3 residents in the applicable sample was completed within 14 days of admission to the home. (Resident #2). Findings include: Per review of the admission assessment for Resident #2 on 8/13/18, the resident assessment was not completed within 14 days of admission. The resident was admitted to the home on 5/6/18 and the state required admission assessment was not completed as signed by the RN, until 5/27/18. The late assessment was confirmed during interview with the Manager at 5:30 PM on 8/13/18.	R135	R135: The action we will take to correct this deficiency is to have the RN assess the residents within the 14 day of admission The RN will attend all of the new admissions and do the assessment on the resident so this does not recur. The manager will monitor new admission dates and work with the RN so this does not recur. The date Corrective action will be completed will be September 4, 2018	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lorna Drake — TITLE: Manager — (X6) DATE: 9-5-18

STATE FORM 6899 OFZD11 If continuation sheet 1 of 5

R135 - R302 POC's accepted 9/10/18 MBolton RN/PMC

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R145	Continued From page 1	R145	R145: The action we will take to correct this deficiency is the RN will develop a care plan to address all of the residents needs, so the resident is able to maintain independence & well-being.	
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the Registered Nurse (RN) failed to develop a care plan to address all of the resident's identified needs for 1 of 3 residents in the applicable sample. (Resident #2). Findings include: Per record review, Resident #2 was admitted to the home on 5/6/18 with a chronic non healing wound, a swallowing deficit and major depressive disorder. The care plan failed to include goals and specific interventions to address these needs. The care plan identified the presence of a wound and stated the resident was at risk of infection, but failed to include that the resident was colonized with an antibiotic resistant bacteria. The care plan stated the need for nectar thick liquids, but no interventions for related to the risk of aspiration and positioning for meals and monitoring during meal times. There was no plan to address medication treatment for depression and assessment for effectiveness of the medication and other interventions. These care plan omissions were confirmed during interview with the Manager during interview on 8/13/18 at 5	R145	The manager will work with the RN on updated care plans and new care plans as they occur. The RN will monitor weekly, resident care plans and all residents and update as needed. The corrective actions will be completed by September 4, 2018	

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R145	Continued From page 2 PM.	R145		
R179 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the home failed to assure that all staff completed the 7 required trainings annually as stated in the Residential Care Home (RCH) Licensing	R179	R179: The action taken to correct the deficiency is to assure all the staff complete the 7 required trainings annually. The measures put into place so the deficent does it recur is the manager will make sure to have all staff attend and sign required trainings book as evidence the employee was present. The corrective actions will be monitored by the manager per monthly trainings. The corrective action will be completed by September 4, 2018.	

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R179	Continued From page 3 Regulations. Two of the five sampled staff training records were incomplete. Findings include: Per review of the staff trainings completed in the previous 12 month period, 2 of 5 staff failed to complete 1 of the 7 Vermont State RCH required annual trainings, specifically "Respectful Effective Communication". The lack of completion of the required training was confirmed during interview with the Manager on 8/13/18 at 5 PM.	R179	The action we will take to correct this deficency will be to conduct fire drills on a quarterly basis and rotate times of the day. The measures put into place so this doesn't recur is to have the manager document times + dates for fire drills quarterly and left in the office. corrective actions will be monitored by the manager. corrective action will be completed by 9-4-18	
R302 SS=D	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the home failed to conduct fire drills during the previous 12 month period for the four required times of the day, as stated in the Residential Care Home licensing regulations. Findings include:	R302		

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R302	Continued From page 4 Based on a review of the fire drills conducted in the previous 12 month period on 8/13/18, the home failed to assure that fire drills were completed during the afternoon hours. The lack of a fire drill during these hours was confirmed during interview with the Manager at 5 PM on the day of survey.	R302		